



**ARMY MEDICINE**  
Serving To Heal...Honored To Serve

# **US Army Patient Safety Center**

## **Johns Hopkins Fall Assessment Tool**

**Quality Management Division**  
**HQ, US Army Medical Command**  
**Fort Sam Houston, TX**

1 June 2011



# Background

- All patients regardless of age are at an increased risk for falling in a hospital setting. Fall and injury prevention continues to be a considerable challenge across the care continuum.
  - Injuries from falls are the 6<sup>th</sup> most commonly reported sentinel event
  - MEDCOM 2010 data revealed 599 inpatient falls; 69 falls resulted in harm



# Purpose

- To standardize endorsed evidence based fall risk assessment tools across all Army Medical Treatment Facilities (MTFs) that provide inpatient nursing care in the electronic medical record (Essentris).
  - In collaboration with the Patient Caring Touch initiative
  - Implementation of tools recommended by the Falls Working Group (Nov 2009) and purchased by the MEDCOM Patient Safety Center



# Goal

- Decrease patient fall events and harmful injuries
- Decrease variation in assessment, interventions, procedures and documentation of falls risk and increase prevention of falls across Army MTFs.



# The Johns Hopkins Adult Fall Risk Assessment Tool

- Stratifies patient interventions based on low, moderate and high risk for falls.
  - Low: 5 points or less
  - Moderate: 6-12 points
  - High: 13 points or greater
- Interventions populated for each risk category.



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# **John's Hopkins Fall Assessment Tool Essentris Documentation**



# Main Screen, includes Fall Risk Factor Category

Select "Patient is at Low Fall Risk" below or "Patient is at High Fall Risk" below

Std Test 1 TEST-1 XXXTest, Kim 99-898-96-9595

Note Edit View

Note Time: 1138 03 Mar 2011 Type: Std Test 1 Topic: N/A  
Last Store At: N/A Last Stored By: (Created) Mode: Edit

**JOHNS HOPKINS FALL ASSESSMENT TOOL**

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## Fall Risk Factor Category

**Step 1: Assess Fall Risk Factor Category; if risk category applies, initiate interventions as assessed.**

Scoring not completed for the following reason(s) (check any that apply).

- ☐ Complete paralysis, or completely immobilized. Implement basic safety (low fall risk) interventions.
- ☐ Patient has a history of more than one fall within 6 months before admission. Implement high fall risk interventions throughout hospitalization.
- ☐ Patient has experienced a fall during this hospitalization. Implement high fall risk interventions throughout hospitalization.
- ☐ Patient is deemed high fall-risk per protocol (e.g. seizure precautions). Implement high fall-risk interventions throughout hospitalization per protocol.

## CALCULATE FALL RISK SCORE

**Step 2: If Fall Risk Factor Category above not applicable, select Calculate Fall Risk Score. (See next slide)**

## Select Patient Risk Level

- ☐ Patient is at Low Fall Risk

**If patient Fall Risk Factor Category applies, select high or low risk as assessed.**

sk



# Calculate Fall Risk Score

Based on Total Points: select "Patient is at Low Fall Risk", "Patient is at Moderate Fall Risk" or "Patient is at High Fall Risk"

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**Step 3: Assess patient fall risk score from drop-down choices below. Selection will auto-populate fall risk score**

<input checked="" type="checkbox"/> CALCULATE FALL RISK SCORE	POINTS
AGE	<input type="text"/>
FALL HISTORY	<input type="text"/>
ELIMINATION, BOWEL AND URINE	<input type="text"/>
MEDICATIONS: INCLUDES PCA/OPIATES, ANTI-CONVULSANTS, ANTI-HYPERTENSIVES, DIURETICS, HYPNOTICS, LAXATIVES, SEDATIVES, AND PSYCHOTROPICS	<input type="text"/>
PATIENT CARE EQUIPMENT: ANY EQUIPMENT THAT TETHERS PATIENT, E.G., IV INFUSION, CHEST TUBE, INDWELLING CATHETERS, SCDs, ETC	<input type="text"/>
MOBILITY: Requires assistance or supervision for mobility, transfer, or ambulation	<input type="text"/>
COGNITION: Altered awareness of immediate physical environment	<input type="text"/>
MOBILITY: Unsteady gait	<input type="text"/>
MOBILITY: Visual or auditory impairment affecting mobility	<input type="text"/>
COGNITION: Impulsive	<input type="text"/>
COGNITION: Lack of understanding of one's physical and cognitive limitations	<input type="text"/>
Total Points	<input type="text"/>

Low risk = 0-5 Total Points  
Moderate risk = 6-13 Total Points  
High risk > 13 Total Points

**Step 3: Assign Risk Level as above**

Select Patient Risk Level

☒ Patient is at Low Fall Risk ☐ Patient is at Moderate Fall Risk ☐ Patient is at High Fall Risk





# Low Fall Risk Interventions

Expanded view of low risk interventions, document as appropriate.

Std Test 1 TEST-1 xxxTEST, NOTE 99-123-00-6789

Note Edit View

Note Time: 1514 04 May 2011 Type: Std Test 1 Topic: N/A  
Last Store At: N/A Last Stored By: (Created) Mode: Edit

☐ CALCULATE FALL RISK SCORE

**Select Patient Risk Level**

☒ Patient is at Low Fall Risk ☐ Patient is at Moderate Fall Risk ☐ Patient is at High Fall Risk

**Low Fall Risk Total Score 0-5 points**

☐ Maintain safe unit environment, including:

- ☐ Remove excess equipment/supplies/furniture from rooms and hallways
- ☐ Coil and secure excess electrical and telephone wires
- ☐ Clean all spills in patient room or in hallway immediately. Place signage to indicate wet floor danger
- ☐ Restrict window openings

☐ The following are examples of basic safety interventions:

- \* Orient patient to surroundings, including bathroom location, use of bed, and location of call light.
- \* Educate patients/families/visitors regarding fall risk and prevention activities
- \* Keep bed in lowest position during use unless impractical (as in ICU nursing or specialty beds)
- \* Keep top two side rails up (excludes box beds). In ICUs, keep all side rails up.
- \* Secure locks on beds, stretchers, and wheelchairs.
- \* Keep floors clutter/obstacle free (with attention to path between bed and bathroom/commode)
- \* Place call light and frequently needed objects within patient reach. Answer call light promptly.
- \* Encourage patients/families to call for assistance when needed.
- \* Display special instructions for vision and hearing.
- \* Assure adequate lighting, especially at night.
- \* Use properly fitting nonskid or double sided footwear
- \* Ensure patient wears snug fitting, non-slip footwear while ambulating.
- \* Clearly identify any hazardous areas or obstacles.
- \* If patient becomes disoriented, attempt reorientation. Reassess falls risk.
- \* Ensure patient eyeglasses are clean and within reach.
- \* Ensure safety strap is in place and/or side rails are up when transporting a patient.



# Moderate Fall Risk Interventions

Expanded view of Moderate Fall Risk Interventions, document as appropriate.

Std Test 1 TEST-1 xxxTEST, NOTE 99-123-00-6789

Note Edit View

Note Time: 1514 04 May 2011 Type: Std Test 1 Topic: N/A  
Last Store At: N/A Last Stored By: (Created) Mode: Edit

☐ CALCULATE FALL RISK SCORE

**Select Patient Risk Level**

☐ Patient is at Low Fall Risk ☒ Patient is at Moderate Fall Risk ☐ Patient is at High Fall Risk

**Moderate Fall Risk Total score 6-13 points**

Visual Cue: YELLOW

- ☐ Post at risk indicator: Yellow wristband, non-skid socks and Falling Star Sign in patient room.
- ☐ Implement measures listed under low fall risk and:
- ☐ Discuss patient at fall risk during shift report rounds
- ☐ Transport throughout hospital with assistance of staff or trained caregiver
- ☐ Do not leave unsupervised off of unit
- ☐ Assess every 2 hours for 4Ps: pain, positioning, pottying, possessions
- ☐ If JHH Fall Assessment cognition score is 1 or greater, consider using a bed exit or personal alarm if available. Check at each change of shift.
- ☐ Supervise and/or assist bedside sitting, personal hygiene, and toileting as appropriate.
- ☐ Reorient confused patients as necessary
- ☐ Establish elimination schedule, including use of bedside commode, if appropriate.
- ☐ Consider use of bed alarm; rapid response to alarm activation
- ☐ Encourage family members to stay with patient when possible
- ☐ Communicate patient fall risk factors to other team members
- ☐ Reorient confused patients, reassess falls risk status
- ☐ Evaluate need for: PT consult if patient has a history of fall and/or mobility impairment.
- ☐ Evaluate need for: OT consult
- ☐ Evaluate need for: Slip resistant chair mat (do not use in shower chair)
- ☐ Evaluate need for: Use of seat belt, when in wheelchair.



# High Fall Risk Interventions

Expanded view of high risk interventions, document as appropriate.

Std Test 1 TEST-1 xxxTEST, NOTE 99-123-00-6789

Note Edit View

Note Time: 1514 04 May 2011 Type: Std Test 1 Topic: N/A  
Last Store At: N/A Last Stored By: (Created) Mode: Edit

☐ Patient is at Low Fall Risk ☐ Patient is at Moderate Fall Risk ☒ Patient is at High Fall Risk

**High Fall Risk Total score > 13 points**  
Visual Cue: YELLOW

- ☐ Post at risk indicator: Yellow wristband, non-skid socks (consider yellow to distinguish from moderate risk) and Falling Star Sign in patient room.
- ☐ Implement measures listed under low/moderate risk and:
- ☐ Discuss patient at fall risk during shift report rounds
- ☐ Assess every 1 hour for 4Ps: pain, positioning, pottying, possessions
- ☐ Remain with patient while toileting
- ☐ If patient requires an air overlay, use side rail protectors.
- ☐ When necessary, transport throughout hospital with assistance of staff or trained caregivers. Consider alternatives, e.g., bedside procedure. Notify receiving area of high fall risk.
- ☐ Encourage family members to stay with patient when possible
- ☐ Move patient to room with best visual access to nursing station
- ☐ Activated bed/chair alarm
- ☐ Low bed
- ☐ Protective devices, e.g. hipsters, helmets
- ☐ Provide distractions such as TV, a task, or volunteer reader
- ☐ 24 hour supervision/sitter
- ☐ Physical restraint / enclosed bed (only with authorized prescriber order)



# Nursing Fall Prevention CPG

- In collaboration with the Patient Touch System of Care, the clinical practice guideline on nursing care to support this initiative can be found at:  
<https://www.qmo.amedd.army.mil/NurseCPG/NurseCPG.html>
- Additional tools to support fall prevention can be accessed through Mosby's On-line.